About Your Benefits

OMNIA[SM]

Horizon

Horizon Blue Cross Blue Shield of New Jersey

HorizonBlue.com/shbp

Welcome!

This *About Your Benefits* guide can help you understand your health insurance plan.

We're happy to have you as a member! Are you ready to get the most from your OMNIA℠ Health Plan?

Follow these steps…

1 Carry your member ID card

It's the key to all your Horizon BCBSNJ benefits. Show it when you see your doctor, or go to a hospital or other health care professional. **Note:** Your member ID card was mailed separately.

2 Get to know your plan

Start with this guide. It will help you understand what's covered and what's not, as well as how to use your benefits. Not sure? Call Member Services at **1-800-414-SHBP (7427)**.

3 Go online

Register for and sign in to Member Online Services at **HorizonBlue.com/shbp**. You'll find benefit details, helpful health and wellness tools, and more.

4 Choose a doctor

Your plan covers doctors and hospitals participating in OMNIA Health Plans. Start by choosing an OMNIA Tier 1-designated doctor to take care of you when you're sick, and help you stay healthier all year round.

See **Section Three: Getting Routine Care** to find out how to choose an OMNIA Tier 1-designated doctor.

5 Save money

Enjoy member-exclusive discounts on fitness and healthy living services. Visit **HorizonBlue.com/blue365** for details.

Horizon

Horizon Blue Cross Blue Shield of New Jersey

24/7 Support

Member Online Services
HorizonBlue.com/shbp

24/7 Nurse Line
1-866-901-7477

Numbers to Know

Member Services
1-800-414-SHBP (7427)

Hearing impaired
711

Representatives are available on Monday, Tuesday, Wednesday and Friday, between 8 a.m. and 6 p.m., Eastern Time (ET), and on Thursday, between 9 a.m. and 6 p.m., ET.

Plan Facts

Name
OMNIA

Participating Health Care Professionals
Refer to **Section Two: Understanding Your Coverage** for details.

Out-of-Network Services
Except for emergency care, services provided by doctors, hospitals and other health care professionals that don't participate in OMNIA Health Plans are not covered.

Connect with us!

@HorizonBCBSNJ

Horizon Connect℠ Retail Center

If you're in the area, stop by and meet the team of experts at our retail center, *Horizon Connect*.

Where: 1680 Nixon Drive, Moorestown, New Jersey

When: Open Monday through Friday, between 9 a.m. and 7 p.m., Eastern Time (ET), and Saturday, between 9 a.m. and 4 p.m., ET.

To make an appointment and register for events, visit **Connect.HorizonBlue.com**.

At *Horizon Connect*, you can:

- Get answers to questions you may have about your plan and benefits.
- Pick up informational materials.
- Learn all about our health and wellness tools.
- Attend health fairs and special events with local doctors, nurses, pharmacists and other health care professionals.
- Purchase health, dental and vision insurance plans.

Use Member Online Services

Our secure Member Online Services site is available to you 24 hours a day, seven days a week.

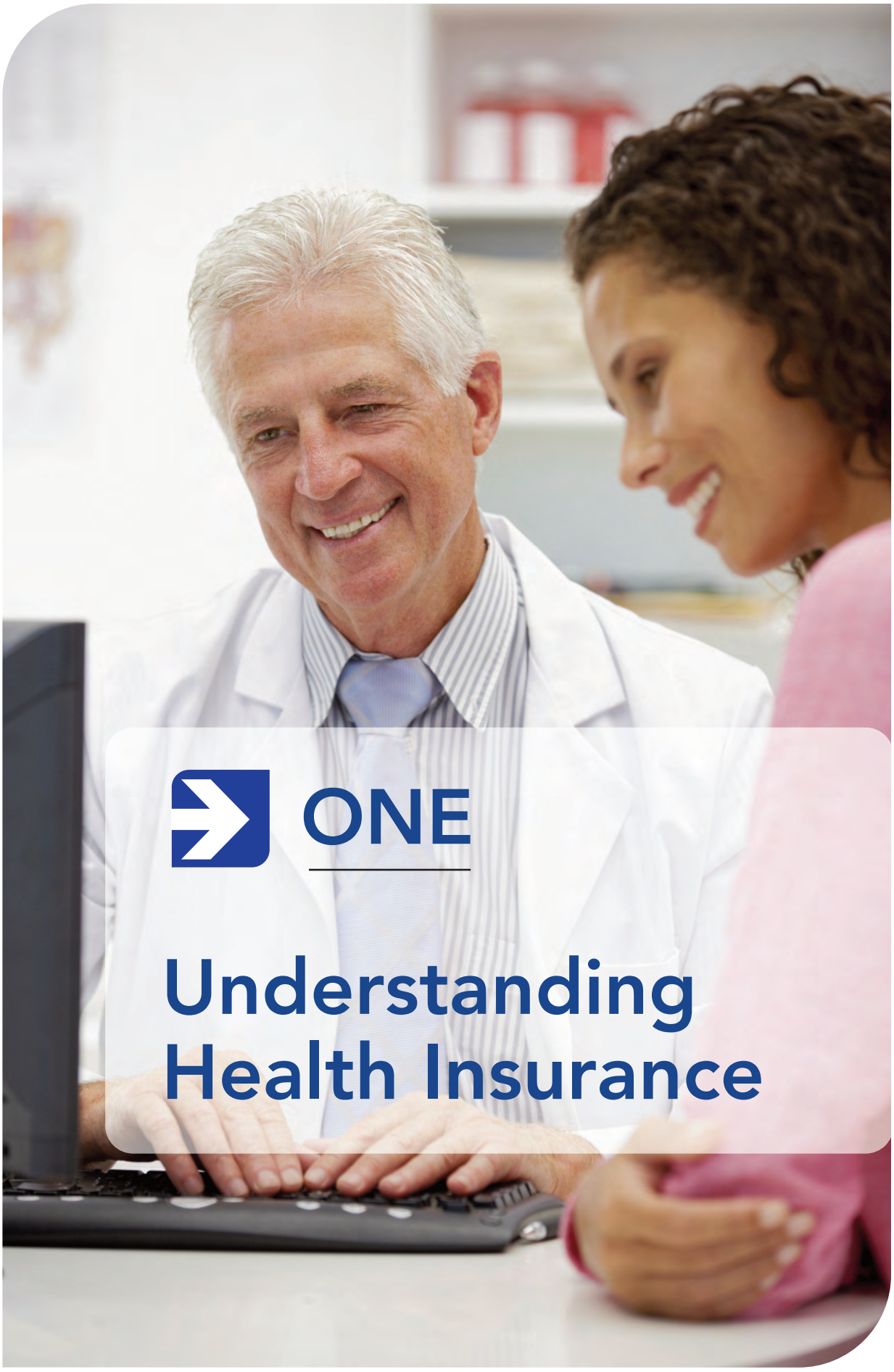
As a registered user of Member Online Services, you can:

- See detailed information about your plan.
- View eligibility and benefits.
- View claim status.
- View authorizations and referrals.
- Display, print or request your member ID card.
- Chat or send a message to a Member Services Representative.
- Change your Primary Care Physician (PCP), if applicable.
- Update your other health insurance coverage information.
- Take advantage of health and wellness tools, educational resources and more.
- Use helpful tools from WebMD®[1] to securely store and track your personal health information.

If you haven't already, start by registering for Member Online Services at **HorizonBlue.com/shbp**.

To use Member Online Services, visit **HorizonBlue.com/shbp** and sign in with your user name and password.

1 WebMD is independent from and not affiliated with Horizon BCBSNJ.

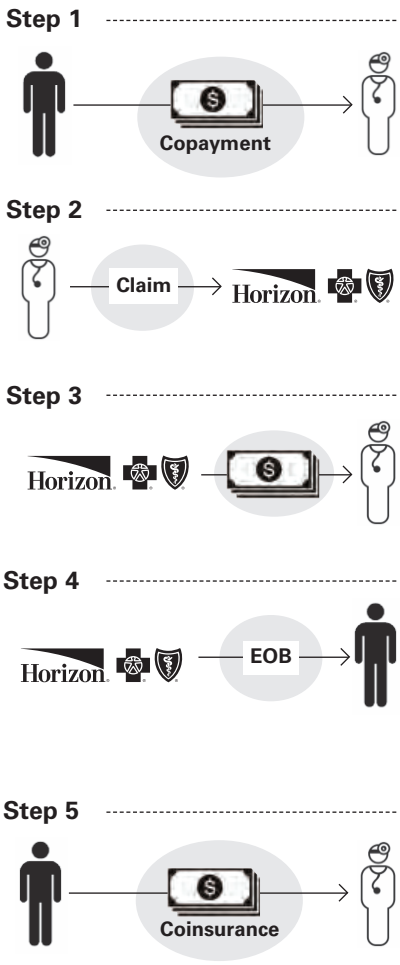


ONE

Understanding Health Insurance

Health insurance may seem complicated and confusing, but it doesn't have to be. At Horizon BCBSNJ, we want to help you understand your health insurance plan – how it works, how to use it and how to get the most out of it.

What to expect



If you've never had health insurance before, you may not know what to expect. In general, here's how it works:

Copayment – A copayment – a fixed amount you pay for each medical visit – may be due when you see an in-network doctor or other health care professional **(Step 1)**.

Claims – The doctor or other health care professional's office files a claim **(Step 2)**, showing which services you received. We process each claim according to the terms of your plan.

If we owe a payment for covered services, we pay the in-network doctor or other health care professional directly **(Step 3)**.

Explanation of Benefits (EOB) – After we process your in-network doctor's or other health care professional's claims, we send you a Horizon BCBSNJ Explanation of Benefits, or EOB **(Step 4)**.

This EOB statement shows how much we paid the doctor or other health care professional for each service, and any amount you may still owe in coinsurance to the doctor or other health care professional **(Step 5)**.

You can view EOB statements when you sign in to Member Online Services. **You can also use Member Online Services to choose to receive your EOBs electronically**.

Medical Bills – After you see an in-network doctor or health care professional, you may not get a medical bill. But you should expect one if you owe a copayment or coinsurance, or if there are charges for services that aren't covered under your plan. **Nonemergent services provided by out-of-network doctors, hospitals and facilities are not covered under your plan, and you will be responsible for the total cost of those services**.

Note: In-network doctors, hospitals and other health care professionals are not permitted to "balance bill" you for any difference between their charges and Horizon BCBSNJ's maximum allowed amount for a covered service. For example, say your doctor charges $200 for a service, and we allow $100 for that service. Because your doctor accepts a discounted rate from Horizon BCBSNJ, the total your doctor gets – our payment, plus your coinsurance and any copayment – is $100. Your doctor can't bill you for the $100 balance.

What do you pay?

Each insurance plan is different. That's why understanding *your* plan and benefits is important. Knowing about your coverage will help you make the best health care choices and avoid unexpected expenses.

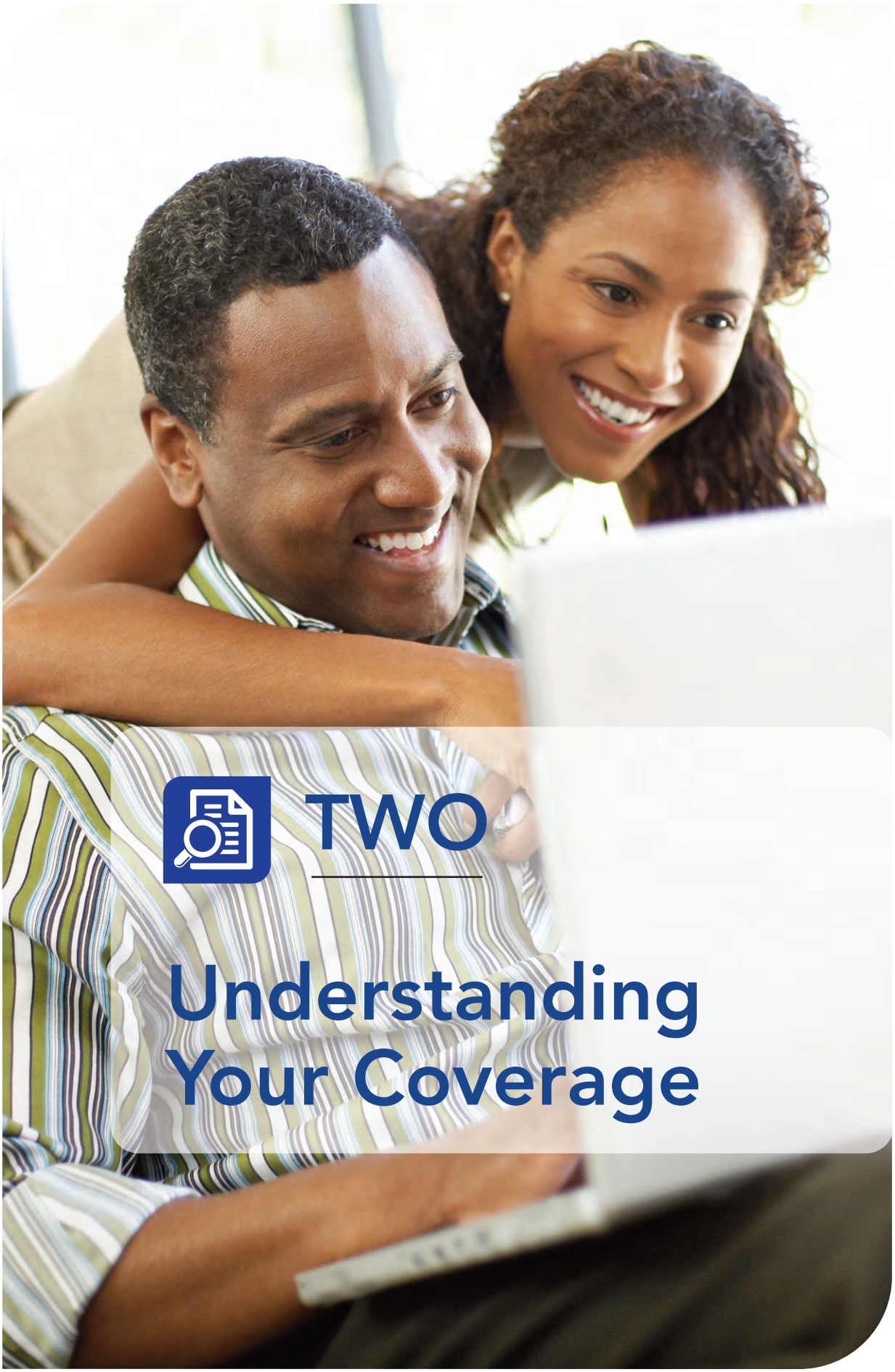
Generally, this is how your health insurance works:

» You pay us a **monthly premium** for coverage. Because you get your insurance through your employer, you pay your premium through payroll contributions.

» Each time you see an in-network doctor, hospital or other health care professional, you may be asked to pay a fixed amount called a **copayment**.

» For some services, you may pay **coinsurance** – a set percentage based on how much we agree to cover for a service (also known as our **allowed amount**). For example, if we allow a $100 charge for a covered service and your plan has 70 percent coinsurance, we would pay $70 and you would be responsible for $30 for that service.

» Finally, your coverage may have an **out-of-pocket maximum limit**. If it does, this amount is the most you'll have to pay "out of your pocket" in copayments, deductibles and coinsurance for certain covered health care services in a single year.



TWO

Understanding Your Coverage

What is Patient-Centered Care?

Patient-centered care is an approach that helps you get the quality health care you need at a more affordable cost. Horizon BCBSNJ is transforming the way health care is delivered in New Jersey by developing the state's largest patient-centered network. Your OMNIA Health Plan offers you the benefits of patient-centered care, along with access to all doctors and other health care professionals in the Horizon Managed Care Network, and all hospitals in the Horizon Hospital Network.

Patient-centered care is all about you. The doctors and practices that participate in OMNIA Health Plans have committed themselves to increasing patient satisfaction and achieving quality health outcomes.

When you select an OMNIA Tier 1-designated doctor as your doctor, you can expect:

» A doctor who takes overall responsibility for your care

» A team of health professionals, led and directed by your doctor, that closely monitors your health and responds to your specific needs

» Wellness services and preventive care based on national guidelines, including wellness support and resources

» Preventive services, screenings and immunizations that are fully covered when you receive them from your doctor or another in-network doctor

When you select and see an OMNIA Tier 1-designated doctor, he or she can help you get the most appropriate care in the right setting. See **Section Three: Getting Routine Care** to learn more about choosing an OMNIA Tier 1-designated doctor and getting care.

OMNIA TIER 1 ICON

Horizon BCBSNJ identifies OMNIA Tier 1-designated doctors, hospitals and other health care professionals with a special icon in our *Online Doctor & Hospital Finder* at **HorizonBlue.com/doctorfinder**.

All other doctors in the Horizon Managed Care Network, the nationwide BlueCard® PPO program and Global Core program, are designated as Tier 2.

Coverage wherever you go

With the BlueCard® Program as part of your OMNIA Health Plan, you have access to the largest health care network in the nation, linking more than 1.3 million doctors, facilities and other health care professionals in the BlueCard PPO program, available outside of New Jersey. You also have access to laboratory testing services.

When you travel outside the country, Global Core provides you with access to care almost anywhere in the world, including hospitals in more than 40 countries.

It's as simple as presenting your Horizon BCBSNJ member ID card to any participating BlueCard or Global Core doctor, other health care professional or hospital. When using participating Blue Cross and/or Blue Shield doctors, you are only responsible for your Tier 2 office visit copayment. A deductible and/or coinsurance may also apply.

Choose *National Doctor & Hospital Finder* at **HorizonBlue.com/doctorfinder** or call **1-800-810-BLUE (2583)** to locate a participating Blue Cross and/or Blue Shield doctor or hospital. Outside the U.S., you can call collect at **1-804-673-1177**.

IMPORTANT TERMS

Copayment – The amount you must pay for each medical visit to an in-network doctor, hospital or other health care professional. Your copayment amounts are listed on your Horizon BCBSNJ member ID card.

Coinsurance – The percentage of a covered charge that Horizon BCBSNJ pays. For example, if your plan has 80 percent coinsurance, you are responsible for 20 percent of covered charges. Coinsurance does not include deductibles, copayments and charges for noncovered services.

Deductible – The amount you must pay each year before benefits are paid by us.

OMNIA Tier 1 – When you receive services from an OMNIA Tier 1 doctor, hospital or other health care professional, you can save money. OMNIA Tier 1 doctors, hospitals and other health care professionals are identified by the following icon in our *Online Doctor & Hospital Finder*:

OMNIA TIER 1

Tier 2 – Under your OMNIA Health Plan, you are still covered at an in-network benefit level when you receive services from a Tier 2 doctor, hospital or other health care professional, identified by the following icon in our *Doctor & Hospital Finder*:

TIER 2

However, you can lower your out-of-pocket costs by receiving services from OMNIA Tier 1 doctors, hospitals and other health care professionals.

Your plan

While your OMNIA Health Plan encourages you to get care from OMNIA Tier 1-designated doctors, hospitals and other health care professionals, your plan covers all medically necessary care and services provided or arranged by doctors and other health care professionals in the Horizon Managed Care Network, and all hospitals in the Horizon Hospital Network.

Under your plan, you're not required to choose a Primary Care Physician (PCP). But when you select and see an OMNIA Tier 1-designated doctor, he or she can help you get the most appropriate care in the right setting.

Questions? Sign in to Member Online Services at **HorizonBlue.com/shbp** to review your coverage information or ask us a question using *Chat* or *eMail Us*. You can also call Member Services to ask a question.

Finding in-network health care professionals

Need to find an in-network doctor, hospital or other health care professional? Use the *Online Doctor & Hospital Finder* at **HorizonBlue.com/doctorfinder**.

To find OMNIA Tier 1-designated doctors:

» Select the type of health care professional you're looking for from the *What are you looking for?* dropdown list and your OMNIA Health Plan from the *Choose a Plan to Start* dropdown list.

To find OMNIA Tier 1 specialists:

» Select a specialty in the *Specialty* dropdown list, or enter a specialty in the *Search* box, and select your OMNIA Health Plan from the *Choose a Plan to Start* dropdown list.

To find OMNIA Tier 1 hospitals:

» Select *Hospitals* in the *What are you looking for?* dropdown list, and your OMNIA Health Plan from the *Choose a Plan to Start* dropdown list.

You can refine your search by entering a ZIP code or other criteria.

You'll pay less when you select and see OMNIA Tier 1 doctors, specialists and hospitals. You can identify OMNIA Tier 1 doctors and specialists by looking for this icon: OMNIA TIER 1

All other doctors will be listed as Tier 2: TIER 2

Services provided by doctors, hospitals and other health care professionals that do not participate in OMNIA Health Plans are not covered. You'll be responsible for the total cost of any of the out-of-network services you receive (except in the case of an emergency).

See page 9 for information on finding in-network doctors, hospitals and other health care professionals outside of New Jersey.

2018 OMNIA Health Plan Benefit Highlights

Access and Cost Sharing	Tier 1	Tier 2
Referrals Required?	No	No
Service Area Available	In NJ Only	Outside NJ (BlueCard & Global Core)
Deductible	$0	$1,500 individual/$3,000 family
Coinsurance	Not Applicable	20%
Maximum Out-of-Pocket (MOOP)	$2,500 individual/$5,000 family	$4,500 individual/$9,000 family
Health Care Services	**Tier 1**	**Tier 2**
Primary Care Physician (PCP) office visit	$5 copayment	$20 copayment
Specialist office visits and consultations	$15 copayment	$30 copayment
Preventive care, screenings, immunizations	No copayment or deductible	No copayment or deductible
Tests & Imaging	**Tier 1**	**Tier 2**
Laboratory: freestanding (LabCorp)	No charge	No charge
Laboratory: hospital outpatient	$15 copayment	Deductible then coinsurance
Radiology: freestanding	No charge	No charge
Radiology: hospital outpatient	$15 copayment	Deductible then coinsurance
Imaging (CT/PET scans, MRIs): freestanding	$15 copayment	Deductible then coinsurance
Imaging (CT/PET scans, MRIs): hospital outpatient	$15 copayment	Deductible then coinsurance
Outpatient Surgery	**Tier 1**	**Tier 2**
Professional charges	No charge	Deductible then coinsurance
Facility charges	$150 copayment	Deductible then coinsurance
Inpatient Services	**Tier 1**	**Tier 2**
Professional charges	No charge	Deductible then coinsurance
Facility charges	$150 per admission	Deductible then coinsurance
Urgent & Emergency Medical Services	**Tier 1**	**Tier 2**
Urgent care	$15 copayment	$30 copayment
Emergency Room	$100 copayment	$100 copayment
Maternity Services	**Tier 1**	**Tier 2**
Prenatal and postnatal care	$5 copayment *(applies to 1st visit only)*	$30 copayment *(applies to 1st visit only*
Delivery and all inpatient services	No copayment	Deductible then coinsurance
Behavioral Health & Substance Use Disorder Services	**Tier 1**	**Tier 2**
Outpatient services (facility)	$15 copayment	Deductible then coinsurance
Outpatient services (office)	$15 copayment	$30 copayment
Inpatient services	No copayment	Deductible then coinsurance
Recovery/Special Health Services	**Tier 1**	**Tier 2**
Home health care	$5 copayment	$5 copayment
Skilled nursing care	$150 per admission	$150 per admission
Durable medical equipment (DME)	No charge	No charge
Hospice services	No copayment	No charge
Ambulance	No charge	No charge

KNOW WHAT YOU OWE

Before you pay any in-network doctor's, hospital's or other health care professional's medical bill, check it against your Horizon BCBSNJ Explanation of Benefits (EOB) statement to see how much we paid and how much you may owe.

Remember, you can see current and past claims any time by signing in to Member Online Services at **HorizonBlue.com/shbp**.

LIMITATIONS AND EXCLUSIONS

Prior authorization: Under your plan, Horizon BCBSNJ must authorize all non-emergency hospitalizations and some specialty care services (except for routine Ob/Gyn) before you receive these types of services.

Noncovered services: Your OMNIA Health Plan does not pay for services or supplies that are not covered under your policy.

Please call Member Services for more details.

What if you get a medical bill?

When you see an in-network doctor or other health care professional, you'll be asked for a copayment, if one applies. For all other charges, the doctor or other health care professional should bill us first by filing a claim.

After we process your claim, you will receive a Horizon BCBSNJ Explanation of Benefits (EOB) statement that explains how much we paid and what you may owe. You may also receive a bill from your doctor or other health care professional for your share of costs (coinsurance plus any covered amount that goes toward meeting your deductible, if applicable).

Always keep a copy of your medical bills for your records.

Enrollment

You are not covered until you enroll in the State Health Benefits Program (SHBP). You must fill out a **Health Benefits Program Application** and provide all the information requested.

If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so.

Open Enrollment periods generally occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the New Jersey Division of Pensions and Benefits.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner or eligible same-sex domestic partner, and your eligible children (as defined below).

Spouse – A person to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

Civil union partner – A person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions and additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or **Fact Sheet #75**, *Civil Unions*, for details).

Domestic partner – A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners) and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or **Fact Sheet #71**, *Benefits Under the Domestic Partnership Act*, for details).

Children – In compliance with the federal Patient Protection and Affordable Care Act (PPACA), coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment.

For a stepchild, provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent and a photocopy of marriage/partnership certificate showing the names of the employee and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate and additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee.

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26.

Dependent children with disabilities – If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, call the Office of Client Services at **1-609-292-7524** or write to the New Jersey Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, NJ 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end.

Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, (2) the child continues to be disabled, (3) the child is unmarried, (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Over age children until age 31 – Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child ***does not*** have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of nonpayment.

See **Fact Sheet #74**, *Health Benefits Coverage of Children until Age 31 under Chapter 375*, for details.

Supporting documentation required for enrollment of dependent

The SHBP is required to ensure that only eligible employees and their dependents are receiving health care coverage under the program. Employees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents and over-age children continuing coverage) must submit supporting documentation in addition to the enrollment application.

Audit of dependent coverage

Periodically, the New Jersey Division of Pensions and Benefits performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

Multiple coverage under the SHBP is prohibited

State statute specifically prohibits two members who are each enrolled in SHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP as an employee or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Medicare coverage while employed

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union or domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD), and the 30-month coordination of benefits period has ended, you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work.

For more information, visit the **New Jersey Division of Pensions and Benefits'** website at **www.nj.gov/treasury/pensions**.

FORMS AT YOUR FINGERTIPS

Got a bill? Need a claim form? You can download a claim form at **shbp.HorizonBlue.com/members/forms** or call Member Services. Mail your completed claim form and bill to the address shown on the form.

THREE

Getting Routine Care

HAVE QUESTIONS?

Go to **HorizonBlue.com/faqs** to read answers to frequently asked questions about benefits, claims, enrollment and more.

If you don't see an answer to your question, you can send us your question through *Chat* or *eMail Us*. Simply sign in to Member Online Services at **HorizonBlue.com/shbp**.

Once signed in to Member Online Services, you can also check the status of a claim, review your benefits, print a member ID card and more.

Doctor Responsibilities

The doctor you choose will be your main resource for health care services. He or she will:

» Handle most of your medical care in his or her own office.

» Perform most of your annual wellness and preventive health exams.

» Take care of your emergency care needs when possible.

» Get prior authorizations from us for medically necessary services.

» Help coordinate the care you get from specialists and other in-network health care professionals.

» Be available on call (or appoint a covering doctor to be available) 24 hours a day, seven days a week.

Making an appointment

ACCESS STANDARDS

To help make sure you can get the medical care you need when you need it, we developed Physician Access Standards for in-network doctors in select specialties[1]. These health care professionals follow our Physician Access Standards[2] when scheduling appointments with you.

» **EMERGENCY CARE – Immediate care**
Includes "a medical condition of such severity that a prudent layperson would call for immediate medical attention and care." To learn more, please see **Section Four: Getting Urgent & Emergency Care**.

» **URGENT CARE – Care within 24 hours**
Includes medically necessary care for an unexpected illness or injury.

» **ROUTINE CARE – Care within two weeks[3]**
Any condition or illness that does not require urgent attention or is not life-threatening, as well as routine gynecological care.

» **ROUTINE PHYSICAL EXAM – Care as soon as possible, but not to exceed four months from the date of your call**
Includes an annual health assessment, as well as routine gynecological exams, for new and established patients.

OFFICE WAITING TIME

Horizon BCBSNJ's in-network doctors are expected to keep office waiting room time to 30 minutes or less from the time of your scheduled appointment, or when you arrive at the office, whichever is later.

If your wait is longer than 30 minutes, you should be given the choice to reschedule or continue waiting.

1 Applies to doctors who are directly under contract with Horizon BCBSNJ.

2 Standards apply to first available appointment, not first convenient appointment.

3 Specialists must offer an appointment for routine care within three weeks.

NIGHTS AND WEEKENDS

If you need urgent care after your doctor's office hours or on weekends, your doctor should be reachable 24 hours a day, seven days a week.

When your doctor is not available, he or she should refer you to a covering doctor who can help you.

If you believe your condition requires emergency care, follow the medical emergency procedures in Section Four: Getting Urgent & Emergency Care.

How to get specialist care

A specialist is a doctor who "specializes" in taking care of a particular bodily system or disease. Cardiologists (heart care) and oncologists (cancer care) are two common types, but there are many more kinds of specialists.

With your OMNIA Health Plan, no referral is needed to see a specialist.

PRIOR AUTHORIZATION

"Prior authorization" means that Horizon BCBSNJ must approve certain specialty services before you receive them. Without proper prior authorization, you might receive services that are not covered by your plan, leaving you responsible for the total cost.

Please call Member Services for more details.

GETTING BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER CARE

Please see page 22 for more information.

HAVE A MEDICAL QUESTION? USE THE 24/7 NURSE LINE

When you have a medical question, but it's not an emergency, our 24/7 Nurse Line[1] is ready to help at no cost to you.

The Horizon BCBSNJ 24/7 Nurse Line is available 24 hours a day, seven days a week, to help you make wise health care decisions. Our team of registered nurses can help you understand a medical problem, review treatment options, answer questions about medications, assist with questions to ask your doctor and more.

Call the 24/7 Nurse Line any time at **1-866-901-7477**. All calls are confidential.

Or sign in to Member Online Services at **HorizonBlue.com/shbp** to chat live with a registered nurse who can answer your questions and provide information on health symptoms, wellness, drugs, up-to-date health news and more.

1 For informational purposes only. Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your doctor's care. The 24/7 Nurse Line services are not an insurance program and may be discontinued at any time. In the event of an emergency, please go to the nearest hospital or doctor or call **911** or your local emergency services number.

FIND A LAB:

You can find the **LabCorp** Patient Service Center nearest you at **labcorp.com/labs-and-appointments**.

You can find the **AtlantiCare Clinical Laboratory** nearest you at **atlanticare.org/index.php/clinical-laboratories**.

How to get a lab test

Laboratory Corporation of America® (LabCorp) and AtlantiCare Clinical Laboratories[1] are the exclusive in-network clinical laboratory providers for members enrolled in OMNIA Health Plans. When you need clinical laboratory tests, your doctor may collect specimens at his or her office or send you to a LabCorp or AtlantiCare patient service center.

If your doctor sends you to a lab, he or she will give you a LabCorp Requisition Form. This form may be used at LabCorp or AtlantiCare Clinical Laboratories. Simply present the form and your Horizon BCBSNJ member ID card when you check in.

Note: If you use a testing facility other than LabCorp or AtlantiCare Clinical Laboratories outside of New Jersey, your tests will be covered as a Tier 2 benefit if you are referred by your doctor. If you get a bill from LabCorp or AtlantiCare Clinical Laboratories, please call Member Services.

* AtlantiCare Clinical Laboratories works in collaboration with LabCorp.

ADVANCED IMAGING SERVICES (AIS) AND CARDIOLOGY IMAGING PROCEDURES

Your doctor must call eviCore healthcare before you receive any of these advanced procedures:

- CT/CTA scans
- Diagnostic left-heart catheterization
- Echo stress tests
- Echocardiograms
- MRIs/MRAs
- Nuclear medicine studies (including nuclear cardiology)
- PET scans

How to get an X-ray or imaging scan (radiology)

Horizon BCBSNJ works with eviCore healthcare[1] for nonemergency, outpatient radiology and diagnostic imaging services. eviCore healthcare will help schedule and manage your office and outpatient radiology and diagnostic imaging, determine whether a service is medically necessary and confirm a location for the service.

SCHEDULING YOUR TESTS

If your doctor decides that you need general radiology (e.g., X-ray, mammogram, ultrasound, etc.), he or she will ask you to call eviCore healthcare's easy-to-use Scheduling Line. The eviCore healthcare scheduling staff will coordinate with the in-network imaging center of your choice to schedule your exam and provide you with a confirmation number that can be used as a referral. You won't need a doctor referral for radiology services.

To make an appointment, call the eviCore healthcare Scheduling Line at **1-866-496-6200**, Monday through Friday, between 7 a.m. and 7 p.m., Eastern Time.

Note: You can make an appointment for radiology services at a hospital outpatient department through eviCore healthcare's Scheduling Line. eviCore healthcare will issue a confirmation number that can be used as a referral.

1 eviCore healthcare is independent from and not affiliated with Horizon BCBSNJ.

What if you need to be hospitalized?

Your OMNIA Health Plan offers coverage at in-network New Jersey hospitals.

To find an in-network hospital, go to the *Online Doctor & Hospital Finder* at **HorizonBlue.com/doctorfinder**, select *Hospitals* in the *What are you looking for?* dropdown, and select your OMNIA Health Plan in the *Choose a Plan to Start* dropdown. Look for hospitals with the OMNIA Tier 1 designation in the search results to maximize your benefits and lower your out-of-pocket costs.

Remember: Except for emergency care, services provided by hospitals that do not participate in OMNIA Health Plans are not covered. You'll be responsible for the total cost of any services you get from out-of-network hospitals.

How to get help with a chronic or serious health condition

The Care Managers in our Chronic Care Program help members who have chronic conditions take better care of their health, understand their care choices and improve their well-being. This program is available at no added cost to eligible members who have:

» Asthma

» Chronic Kidney Disease (CKD)/End-Stage Renal Disease (ESRD)

» Coronary Artery Disease (CAD)

» Chronic Obstructive Pulmonary Disease (COPD)

» Diabetes

» Heart Failure

To learn more about Horizon BCBSNJ Chronic Care Programs or to enroll, visit **HorizonBlue.com/chronic-care** or call **1-888-345-1150**, Monday through Friday, between 8 a.m. and 7 p.m., Eastern Time. If you use TTY services, please call **711** during the same hours.

If you're diagnosed with a serious medical condition or told that you need major surgery, you may be eligible for our Case Management Program.

Think of your Care Manager as your link to Horizon BCBSNJ, helping you navigate your coverage to get the right care at what could be a difficult, stressful time. Each Care Manager is a registered nurse who is trained to help you examine your options for available specialists, hospitals and medical care while maximizing your health plan benefits.

If you face a challenging medical condition, let our Care Managers help – at no additional cost to you. You can reach a Care Manager at **1-888-621-5894**, option **2**, Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

HOSPITAL STAYS AND PRIOR AUTHORIZATION

For your inpatient or outpatient[1] hospitalization to be covered, your doctor must contact us for prior authorization, and you must receive care from an in-network facility.

If you receive care at an out-of-network hospital when it's not an emergency, you'll be responsible for the total cost.

1 Not all outpatient hospital services require prior authorization.

CARE MANAGER DUTIES

A Horizon BCBSNJ Care Manager can educate you about your condition, help you get quality medical care, secure appropriate authorizations and connect you to valuable resources. If your medical condition requires hospitalization, your Care Manager will see to it that your follow-up needs are met when you leave the hospital.

Your Care Manager can also help you improve your health, work with you to prevent complications, help you live within the boundaries of a new health status, and assist you and your family with adjusting to a new lifestyle that optimizes your quality of life.

What if you become pregnant?

If you become pregnant, your Horizon BCBSNJ health plan will be with you and your obstetrician every step of the way, with comprehensive prenatal and maternity coverage.

PARTNERING WITH YOUR OB/GYN

Horizon BCBSNJ supports the American College of Obstetricians and Gynecologists' recommendation for 12 obstetrical visits during a normal pregnancy. Your doctor will decide how many visits are right for you.

If your doctor decides you need more specialized care, you may be referred to a Care Management Nurse. This registered nurse will help ensure that you and your unborn baby have the most appropriate care. To learn more about our Case Management services, please call **1-888-621-5894**, option **2**.

MATERNITY HOSPITAL STAYS

New mothers are certified for a hospital stay of 48 hours following a vaginal delivery or 96 hours following a caesarean section. Your hospital stay may be extended if your doctor thinks it's medically necessary. To be covered, your doctor will need to contact us for approval of the additional days.

Your doctor may decide that you're ready to leave the hospital early – within one day after a vaginal delivery or within two days after a caesarean section. If you do leave early, you become eligible for a home care visit to support your move from hospital to home. To be covered, your doctor must schedule the visits to occur within seven (nurse/lactation consultant) to 14 (home health aide) days after you've left the hospital.

MATERNITY HEALTH COACH

You may also have access to a Maternity Health Coach through the 24/7 Nurse Line. Registered nurses will provide one-on-one counseling and educational support to help address your:

» Pregnancy concerns

» Health issues that might affect your pregnancy or delivery

» Questions that you may have during and after your pregnancy

Your Maternity Health Coach will help you throughout your pregnancy so you can feel comfortable about the healthy choices you make for you and your baby.

Eligible members can reach a Maternity Health Coach at **1-866-901-7477**, option **3**, Monday through Friday, between 8 a.m. and 8 p.m., Eastern Time.

PRECIOUS ADDITIONS®[1]

As an expectant mother, you may have questions and concerns about your pregnancy and delivery. That's why we developed the **PRECIOUS ADDITIONS** program.

PRECIOUS ADDITIONS is an educational program where eligible members can receive information about pregnancy, childbirth, the postpartum period and their child's first year of life. The program will help provide guidance for making healthy and safe choices during this special time.

Eligible members can enroll in **PRECIOUS ADDITIONS** by visiting **HorizonBlue.com/preciousadditions** or by calling Member Services.

1 Some products and services included in the PRECIOUS ADDITIONS program materials are provided by independent companies. These companies are solely responsible for their products and services.

What if you need behavioral health or substance use disorder care?

Your Horizon BCBSNJ health plan includes behavioral health and substance use disorder coverage. Horizon Behavioral Health℠ provides assistance with a wide range of emotional and relationship issues, depression, alcoholism, addictions and more, through an extensive network of health care professionals and facilities.

AVAILABLE SERVICES

Horizon Behavioral Health professionals offer a full range of counseling services, including:

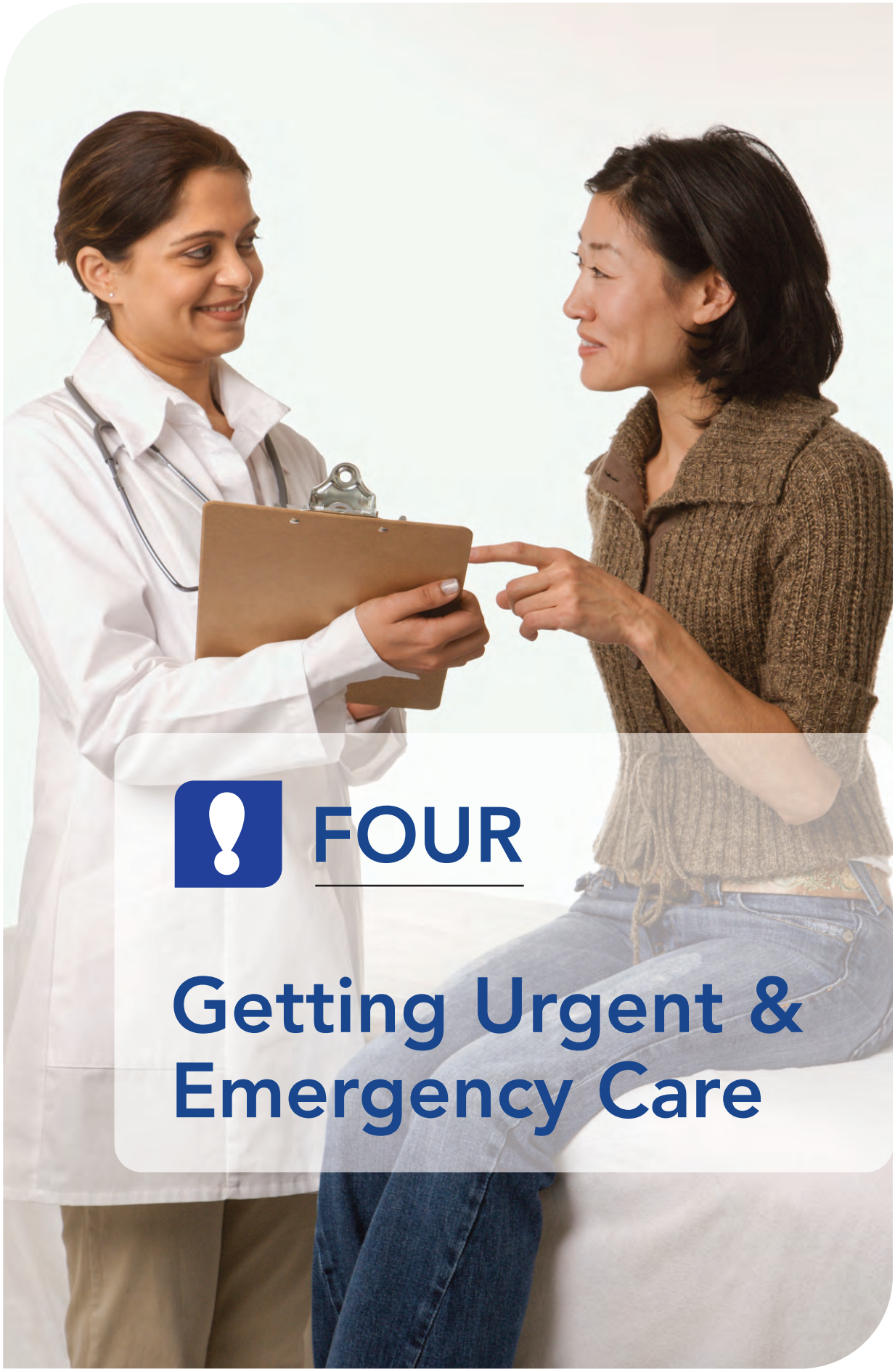
- Individual and group psychotherapy
- Family counseling and crisis intervention
- Addiction recovery programs
- Autism care management program

GETTING BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER CARE

For routine behavioral health or alcohol/substance use disorder care,[1] please call Horizon Behavioral Health at **1-800-991-5579**. Behavioral health and substance use disorder care is available 24 hours a day, seven days a week. All calls are confidential.

Prior authorization is required for all inpatient behavioral health and substance use disorder care.

1 Due to the confidential nature of these services, you may need to authorize the disclosure of treatment information during or after your course of treatment. Authorization might also be needed to allow any individual (including family members) to get a member's behavioral health/substance use disorder treatment information.



FOUR

Getting Urgent & Emergency Care

Immediate care

You may have an urgent medical condition – one that can't wait for a normal appointment but is not a true medical emergency, either.

For urgent care, contact your doctor or his or her covering doctor first. He or she can help you determine the type of care that is best for you.

YOUR URGENT CARE OPTIONS:

Your Doctor

Call first, especially if you're not sure it's really an emergency. Your doctor may tell you how to treat the condition yourself, send you to the nearest urgent care center or make an appointment to see you as soon as possible.

24/7 Nurse Line[1] (1-866-901-7477)

The 24/7 Nurse Line is always available to answer your medical questions. When you call, a registered nurse will help you decide whether a condition is urgent or a true medical emergency.

Urgent Care Center

An urgent care center may be a good alternative when you need care right away. You'll probably have a much shorter wait for non-critical care than at an Emergency Room (ER), and your out-of-pocket costs may be lower, too. You can find an urgent care center by using the *Online Doctor & Hospital Finder* at **HorizonBlue.com/doctorfinder**.

Note: Routine office visits, annual physicals, sports physicals, routine obstetric services, occupational medicine and physical therapy are not covered at urgent care centers.

Emergency Room

For treatment of a severe illness or injury, go to the nearest ER right away, or call **911** or your local emergency number.

1 Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your doctor's care. In the event of an emergency or if you believe you have a life-threatening medical situation, please go to the nearest hospital or call **911** or your local emergency number.

IS IT REALLY AN EMERGENCY?

Knowing the difference between urgent care and a medical emergency can save you time and money.

Urgent care situations include:

- Sprains
- Earache
- Moderate fever
- Sore throat

This is not a complete list of urgent care situations. For these and other common medical conditions, call your doctor or visit an urgent care center.

Medical emergencies include:

- Severe burns
- Heart attacks and strokes
- Poisoning
- Obvious bone fractures
- Wounds requiring sutures
- Loss of consciousness

This is not a complete list of emergency situations. For these and other serious or life-threatening conditions, seek immediate treatment by going to an ER, or call **911** or your local emergency response number.

HORIZON BCBSNJ HEALTH TIP

Don't miss out on your preventive care benefits. Be sure to make appointments for physical examinations and related services well in advance. See **Section Five: Taking Care of Yourself & Your Family** for more on preventive care benefits and guidelines.

Emergency care

In general, an emergency is defined as "a medical condition of such severity that a prudent layperson with average knowledge of health and medicine would call for immediate medical attention."

If you reasonably believe that a condition is a medical emergency:

1. **Go directly to the nearest ER or call 911 or your local emergency response number.**
2. **Call your doctor.** In some situations, you may be able to call your doctor before you go to the ER. If you can't, call as soon as reasonably possible, or ask a family member or friend to call. It is important that your doctor be kept aware of your condition. Without this information, he or she cannot coordinate your care.

You do not need to call Member Services to notify us of a medical emergency.

MEDICAL EMERGENCY SCREENING EXAM

Sometimes, you may not be sure if your condition requires emergency care. Your plan covers a medical emergency screening exam, which is an evaluation performed in a hospital ER by qualified health care personnel, to determine if a medical emergency exists. We'll cover the cost of the medical emergency screening exam.

If the exam determines that an emergency does not exist, please follow up with your doctor.

If you continue to receive care at the ER after you have been advised that your condition is not a medical emergency, you will have to pay the total cost for any non-emergency-related services you receive.

EMERGENCY ROOM COPAYMENTS

Even if your doctor refers you to the ER, **you'll have an ER copayment and may also be responsible for a deductible and coinsurance**. Each time you are treated at an ER or are given a medical emergency screening exam, you will be responsible for a copayment as well as any coinsurance your plan requires. But if you're admitted to the hospital as an inpatient within 24 hours, we'll waive the ER copayment.

FOLLOW-UP CARE AFTER AN EMERGENCY ROOM VISIT

Contact your doctor. He or she should coordinate all medical emergency follow-up care.

FIVE

Taking Care of Yourself & Your Family

CHILDHOOD IMMUNIZATIONS

Are your children up to date on immunizations?

The Centers for Disease Control and Prevention (CDC) has recommended catch-up schedules for children and adolescents who start late or fall behind on their immunizations. Usually, there's no need to restart a vaccine series regardless of the time between doses. Ask your child's pediatrician for guidance.

For additional reasons to vaccinate children and adolescents in high-risk groups, for the recommended catch-up schedule, and immunization charts in English and Spanish, visit **cdc.gov/vaccines**.

NOTES:

» Horizon BCBSNJ preventive care guidelines are continually reviewed and may change.

» Always discuss your particular preventive care needs with your doctor. He or she will help you decide which preventive care services are appropriate for you.

» Some of the services and supplies described in our preventive care guidelines may not be covered benefits under your health plan.

Getting preventive care

One of your most important Horizon BCBSNJ benefits is the one you use when you're not sick – our wellness and preventive care coverage. Taking advantage of your covered preventive care services – checkups and counseling – may improve your health and help you avoid illness. Best of all, when you see your in-network doctor, routine preventive care is available at no additional cost to you.

We encourage you to visit your doctor for annual physical examinations. Early detection of any illness offers your best chance for recovery.

Well and preventive care coverage includes:

- Annual physical exams
- Well child care (including immunizations and lead screenings)
- Cancer screenings (including colorectal, breast, cervical and prostate)
- Tests (laboratory work, X-rays)

Preventive health care guidelines

Getting the right wellness and preventive care starts with a conversation between you and your doctor. Here's where to start:

For adults

» Schedule annual physical exams

» Ask your doctor about any additional screenings, examinations and immunizations that may be appropriate for you

For children

» Consult your child's doctor about specific recommendations for examinations, screenings, tests and vaccines

For a complete list of the preventive health guidelines, visit **HorizonBlue.com/preventive**.

Please call Member Services for more details.

Wellness programs

At Horizon BCBSNJ, we take your health and wellness seriously and believe that wellness is key to happiness. That's why we've made it easier for you to set and achieve your wellness goals. Horizon Wellness gives you access to:

Blue365®[1]

Get healthy living discounts from top national and local retailers delivered weekly right to your inbox. You'll get deals on:

- **Financial Health:** Cell phone service plans, home mortgages and more
- **Fitness:** Memberships, special events and apparel
- **Healthy Eating:** Weight-management programs and specialty food services
- **Lifestyle:** Hotels, retailers and more
- **Personal Care:** Products and services that can keep your body looking and feeling good
- **Wellness:** Services designed to help you live a healthier life

1 Blue365 offers access to savings on items and services that members may purchase directly from independent vendors. The Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Also, neither Horizon BCBSNJ nor the BCBSA recommend, warrant or guarantee any specific Blue365 vendor or discounted item or service.

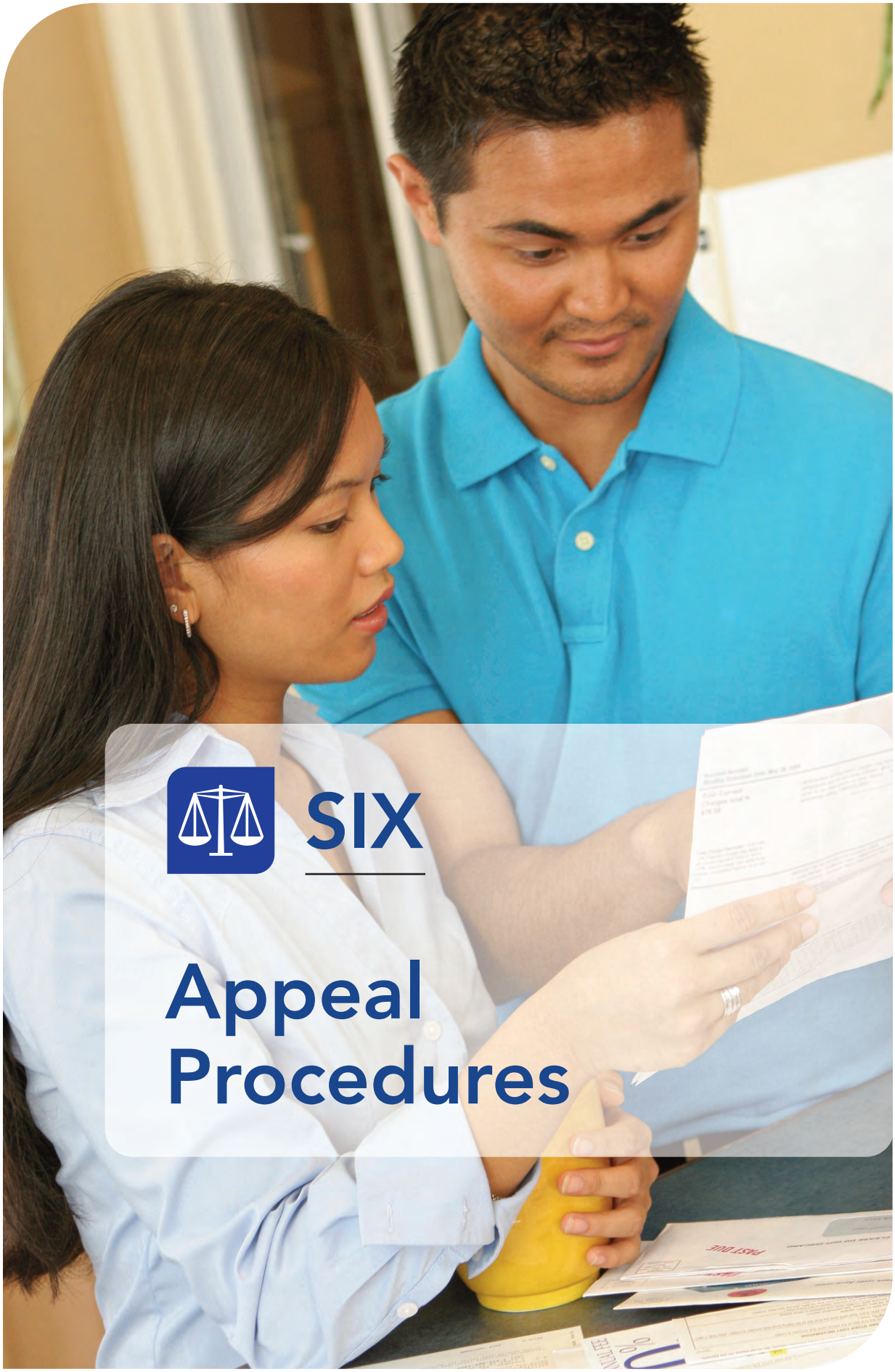
NJWELL

NJWELL is the wellness program for actively employed SHBP/SEHBP employees and their eligible spouses/partners.

By encouraging employees to take ownership of their health, the SHBP/SEHBP hopes to increase overall wellness and rewards eligible employees and their covered spouses/partners for completing activities geared toward health and wellness, including completing an online health assessment.

To complete the online health assessment and track your NJWELL progress, you need to be registered for Horizon BCBSNJ's secure Member Online Services and My Health Manager available on **HorizonBlue.com/shbp**.

Learn more about NJWELL on **HorizonBlue.com/shbp** and **www.nj.gov/njwell**.



SIX

Appeal Procedures

Medical Appeal Procedure

Member appeals that involve medical judgment made by Horizon BCBSNJ are considered medical appeals. An adverse benefit determination involving medical judgment is (a) a denial; or (b) a reduction from the application of clinical or medical necessity criteria; or (c) a failure to cover an item or service for which benefits are otherwise provided because Horizon BCBSNJ determines the item or service to be experimental or investigational, cosmetic, or dental, rather than medical. Adverse benefit determinations involving medical judgment may usually be appealed up to three (3) times as outlined below:

- **First Level Medical Appeal –** The First Level Medical Appeal of an adverse benefit determination.
- **Second Level Medical Appeal –** The Second Level Medical Appeal of an adverse benefit determination available to you after completing a First Level Medical Appeal.
- **External Appeal –** The Third Level Medical Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Medical Appeal. An External Appeal provides you the right to appeal to an Independent Review Organization (IRO).

An overview of the medical appeal procedure is provided below.

FIRST LEVEL MEDICAL APPEAL

First Level Medical Appeals may be submitted in writing or verbally. Verbal appeals may be directed to Horizon BCBSNJ Utilization Management at **1-888-221-6392**. Written appeals may be sent to:

Horizon BCBSNJ Medical Appeals
Mail Station PP 12E
P.O. Box 420
Newark, NJ 07101-0420

The member, physician or authorized representative has one (1) year following your receipt of the initial adverse benefit determination letter to request a medical appeal.

To initiate a First Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved
- Member's identification number
- Date(s) of service
- Nature and reason behind your appeal
- Remedy sought
- Clinical documentation to support your appeal

First Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard First Level Medical Appeals not related to substance use disorders, are reviewed and decided within 15 calendar days from Horizon BCBSNJ's receipt of the appeal.
- First Level Expedited (urgent and emergent) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon BCBSNJ's receipt of the appeal request.
- First Level Medical Appeals related to pre-service substance use disorder claims are reviewed and decided within 24 hours from Horizon BCBSNJ's receipt of the appeal.

The member will receive a letter documenting Horizon BCBSNJ's first level medical appeal decision. The letter will include the specific reasons for the determination.

EXPEDITED REVIEW

Horizon BCBSNJ medical appeal procedures may be expedited in circumstances involving urgent or emergent care.

First and Second Level Medical Appeals are automatically handled in an expedited manner for all determinations regarding urgent or emergent care, an admission, availability of care, continued stay, or health care services for which the claimant received emergency services but has not been discharged from the facility. Furthermore, if you feel that the Horizon BCBSNJ adverse benefit determination decision will cause serious medical consequences in the near future, you have the right to an expedited medical appeal. You also have the right to an Expedited Medical Appeal if in the opinion of a physician with knowledge of your medical condition, your condition is as described above or that you will be subject to severe pain that cannot be adequately managed without receiving the denied medical services. Expedited Medical Appeals are initiated by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**.

SECOND LEVEL MEDICAL APPEALS

Except with respect to appeals related to substance use disorders, if you disagree with the First Level Medical Appeal decision, you have one (1) year following receipt of Horizon BCBSNJ's original determination letter to request a Second Level Medical Appeal. If you wish to make a Second Level Medical Appeal, you may do so by sending your appeal in writing to:

Horizon BCBSNJ Appeals Department
Mail Station PP-12E
P.O. Box 420
Newark, NJ 07101-0420

You may also initiate a Second Level Medical Appeal by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392.**

To initiate a Second Level Medical Appeal, the following information must be provided:

- Name and address of the member or provider(s) involved
- Member's identification number
- Date(s) of service
- Nature and reason behind your appeal
- Remedy sought
- Clinical documentation to support your appeal

If a Second Level Medical Appeal is received, it is submitted to the Horizon BCBSNJ Appeals Committee. The Appeals Committee is made up of Horizon BCBSNJ medical directors and staff, physicians from the community and consumer advocates. A smaller subcommittee reviews Expedited Second Level Medical Appeals. The Appeals Coordinator will advise you of the date of your hearing. You have the option of attending the hearing in person or via telephone conference. You may also elect to have the Appeals Committee review and decide your Second Level Medical Appeal without your appearance.

Second Level Medical Appeals will be reviewed and decided in the following time frames:

- Standard Second Level Medical Appeals are reviewed and decided within 15 calendar days from Horizon BCBSNJ's receipt of the appeal.
- Second Level Expedited (urgent and emergent circumstances, as previously described) Medical Appeals are decided as soon as possible in accordance with the medical urgency of the case, but will not exceed 72 hours from Horizon BCBSNJ's receipt of your first level medical appeal request.

If you participate in the hearing, you will be notified of the Appeals Committee's decision verbally by telephone on the day of the hearing whenever possible. Written confirmation of the decision is sent to you and/or your physician or other authorized representative who pursued the Second Level Medical Appeal on your behalf. If you choose not to appear at the hearing you will be notified of the Appeals Committee's decisions in writing within five (5) business days of the decision. Horizon BCBSNJ's letter will include the specific reasons for the determination. If Horizon BCBSNJ's decision is not in your favor, you have the right to pursue an External Appeal through an Independent Review Organization (IRO).

Expedited Review of Second Level Medical Appeals

If the circumstances previously described in the "Expedited Review" section apply in your case, you have the same right to an expedited review of your Second Level Medical Appeal.

External Appeal Rights

STANDARD EXTERNAL APPEALS

If you are dissatisfied with the results of Horizon BCBSNJ's internal appeals process, and you wish to pursue an External Appeal with an Independent Review Organization (IRO), you must submit a written request within four (4) months from your receipt of Horizon BCBSNJ's final adverse benefit determination of your appeal. To initiate a standard External Appeal, you should submit a written request to:

Horizon BCBSNJ Appeals Department
Mail Station PP-12E
P.O. Box 420
Newark, NJ 07101-0420

Upon receipt of your written request, a preliminary review will be conducted by Horizon BCBSNJ and completed within five (5) business days to determine:

- Your eligibility under your group health plan at the time the service was requested or provided
- That the adverse benefit determination does not relate to your failure to meet eligibility requirements under the terms of your group health plan (e.g., worker classification or similar)
- The internal appeals process has been exhausted (if required)
- You have provided all the information and forms required to process the external review

After the completion of this preliminary review, written notification will be issued informing you of Horizon BCBSNJ's determination regarding the eligibility of your request for external review. If your request for an external review meets the eligibility requirements, your appeal will be assigned to an IRO by Horizon BCBSNJ. The IRO will notify you in writing of your request's eligibility and acceptance for external review. The IRO will review all of the information and documents received and will provide its written final external review decision to the claimant and Horizon BCBSNJ within 45 days after the IRO first received the request for the external review. Upon receipt of a final external review decision reversing an adverse benefit determination, Horizon BCBSNJ will provide coverage or payment for the claim(s) or service(s) involved. If the final external review decision upholds the adverse benefit determination, no further action is taken and the medical appeals process is complete.

The standard External Appeal rights described may be expedited in the following circumstances:

The initial adverse benefit determination involving medical judgment concerns a medical condition such that the completion of a standard internal appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, and the member has filed a request for an expedited Internal Appeal,

OR

The final adverse benefit determination (decision upon appeal) involving medical judgment concerns a medical condition such that the completion of a standard External Appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, or if final adverse benefit determination involving medical judgment concerns an admission, availability of care, continued stay or a health care item or service for which the member received emergency services, but has not been discharged from the facility.

In instances of an expedited request, your request can be made by calling a Horizon BCBSNJ Appeals Coordinator at **1-888-221-6392**. For expedited external review requests, the final notice of the decision must be provided as expeditiously as the member's medical condition or circumstances require, but in no event shall exceed 72 hours from the IRO's receipt of the request for expedited external review.

External Appeal rights related to substance use disorders

If you are dissatisfied with the results of Horizon BCBSNJ's internal appeals process with respect to a substance use disorder claim and you wish to pursue an External Appeal with an Independent Review Organization (IRO), you must submit a written request in accordance with the procedures outlined in the External Appeal Rights section above. The IRO will review all of the information and documents received and will provide its written final external review decision to the claimant and Horizon BCBSNJ within 24 hours from the IRO's receipt of the request for external review.

Administrative Appeal Procedure

The member or the member's authorized representative may appeal and request that Horizon BCBSNJ reconsider any claim or any portion(s) of a claim for which they believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be on an administrative nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Examples of administrative appeals include:

- Visits beyond the 25-visit chiropractic limit
- Benefits beyond the reasonable and customary allowance
- Routine vision services rendered out-of-network
- Benefits for a wig that exceed the $500/24 month limit
- Hearing aid for a 60-year old member

Adverse benefit determinations involving the application of plan benefits may usually be appealed up to three (3) times as outlined below:

- **First Level Administrative Appeal –** The First Level Administrative Appeal of an adverse benefit determination.
- **Second Level Administrative Appeal –** The Second Level Administrative Appeal of an adverse benefit determination available to you after completing a First Level Administrative Appeal.
- **Commission Appeal –** The Third Level Administrative Appeal of an adverse benefit determination, which, at your request, would generally follow a Second Level Administrative Appeal. A Commission Appeal provides you the right to appeal to the State Health Benefits Commission (Commission).

An overview of the administrative appeal process is provided below.

FIRST LEVEL ADMINISTRATIVE APPEAL

The member may request an administrative appeal by calling **1-800-414-SHBP (7427)** or submitting a written appeal to:

Horizon BCBSNJ
OMNIA Health Plan Appeals
P.O. Box 820
Newark, NJ 07101

The member has one (1) year following the receipt of the initial adverse benefit determination letter to request an administrative appeal.

The First Level Administrative Appeal should include the following information:

- Name and address of the patient and the OMNIA Health Plan member
- Member's identification number
- Date(s) of service(s)
- Provider's name and identification number
- Physician's name and identification number
- The reason you think the claim/service should be reconsidered
- All documentation supporting your appeal

You will receive a written response to your First Level Administrative Appeal within 30 days. If you are not satisfied with this written determination, a Second Level Administrative Appeal may be requested.

SECOND LEVEL ADMINISTRATIVE APPEAL

The member may request a Second Level Administrative Appeal within one (1) year following receipt of the initial adverse benefit determination letter by calling **1-800-414-SHBP (7427)**, or by writing to the address noted earlier. The member may also send an appeal via fax to **1-973-274-4599**.

During the Second Level Administrative Appeal, Horizon BCBSNJ will review any additional evidence the member wished to supply in support of the appeal. The member will receive a written determination of the final decision within 30 days. This will complete the Horizon BCBSNJ appeal options.

COMMISSION APPEAL

Once all appeal options have been exhausted through Horizon BCBSNJ, the member may appeal to the State Health Benefits Commission (Commission). If dissatisfied with a final Horizon BCBSNJ decision on an administrative appeal, you have one (1) year following receipt of the initial adverse benefit determination letter to request a Commission Appeal. Only the member or the member's legal representative may appeal, in writing, to the Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to:

Appeals Coordinator
State Health Benefits Commission
P.O. Box 299
Trenton, NJ 08625-0299

The member will be advised by the Commission how to arrange a hearing date, the date of the hearing and the option to attend and appear before the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request in writing to the Commission, within 45 days, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify or reject.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. The member will be responsible for any expenses involved in gathering evidence or material that will support the grounds for appeal. The member will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If an attorney or expert medical testimony is required, the member will be responsible for any fees or costs incurred.

If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

SEVEN

Important Information

Your rights

As a Horizon BCBSNJ member, you have the right to:

- Be provided with information in a way that works for you (in languages other than English and in alternate formats, such as large print). If you need help understanding this Horizon BCBSNJ information, you have the right to get help in your language at no cost to you. To speak with an interpreter, call **1-800-414-SHBP (7427)** during normal business hours.
- Timely access to covered services and medications, as applicable.
- Receive information about Horizon BCBSNJ and it services, policies and procedures, products, doctors, appeal procedures, member rights and responsibilities, coverage limitations, and other information about the organization and care provided.
- Be provided with the information needed to understand your benefits and obtain care.
- Receive prompt notification of termination of your Primary Care Physician (PCP), if applicable, or material changes in benefits, services or network within 30 days prior to the date of any change or termination, as appropriate.
- Obtain information about whether a referring doctor has a financial interest in the facility or services to which a referral is being made.
- Choose and change your PCP, as applicable, within the limits of your benefits and the doctor's availability.
- Go to an Emergency Room (ER) without prior approval when it appears to you that serious harm could result from not obtaining immediate treatment.

Your responsibilities

As a Horizon BCBSNJ member, you have the responsibility to:

- Read and understand this *About Your Benefits* guide, your policy and all other materials about your plan and coverage.
- Be considerate and courteous to doctors and staff.
- Coordinate nonemergency care through your PCP.
- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care.
- Follow plans and instructions for care that you have agreed to with your doctors.
- Pay for charges, including copayments, deductibles and coinsurance as stated in your plan, as well as for any charges you incur for noncovered care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

This is a partial list of your member rights and responsibilities. For a complete list of rights and responsibilities, along with more information about your relationship with Horizon BCBSNJ, please visit **HorizonBlue.com/rights** or call Member Services. Member Rights and Responsibilities are distributed annually to members and upon enrollment for new members.

If you do not have access to the Internet, you may call Horizon BCBSNJ's Member Services at **1-800-414-SHBP (7427**).

How to make inquiries, complaints and appeals

At Horizon BCBSNJ, we're dedicated to providing all our members with access to quality health care and service. Your plan offers inquiry, complaint and appeal processes designed to provide prompt response and resolution to all requests.

These processes relate to:

- Medical issues
- Our utilization management decision making
- Other nonutilization management issues

Please call Member Services for more details.

Coordination of benefits with other health coverage

If you or a covered member of your family also has health coverage under Medicare or with any other insurer, you must let us know.

To avoid duplication of coverage, we coordinate your Horizon BCBSNJ plan benefits with those provided by Medicare or the other insurer. Depending on your policy, either Horizon BCBSNJ or your other insurer is considered **primary**.

- If your other plan is primary, claims go to that plan first. In this case, Horizon BCBSNJ's coverage would be **secondary** – we consider each claim for payment after it has been processed by the other plan.
- If your Horizon BCBSNJ plan is **primary**, we process your claims first without regard to any other insurance coverage.
- In any case, Horizon BCBSNJ won't pay more for claims than we would have if we had been your only health care plan.

To update your other insurance coverage information, sign in to Member Online Services at **HorizonBlue.com/shbp**, choose *My Coverage*, then *Update Additional Insurance*.

If you have questions, call Member Services.

Results of independent satisfaction surveys

You can get results of independent consumer satisfaction surveys and analysis of quality outcomes for health care services provided under managed care plans in New Jersey.

Send your request to:

Actuarial Bureau
New Jersey Department of Banking and Insurance
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325

Or call:

1-609-292-5427

Continuation-of-care benefits

If you are receiving covered services (other than obstetrical care, post-operative care, oncological treatment or psychiatric treatment) from a terminated health care professional who was under contract with us at the time your treatment started, you may continue care or services with that health care professional for up to four months where medically necessary.

If you are receiving obstetrical care, post-operative care, oncological treatment or psychiatric treatment from a terminated health care professional who was under contract with us at the time your treatment started, you may continue to be treated by that health care professional for the duration of the treatment or care:

» **Pregnancy:** Coverage of services will continue through the postpartum evaluation, up to six weeks after delivery.

» **Post-operative follow-up care:** Coverage of services may continue for up to six months from the date of the health care professional's termination.

» **Oncological treatment:** Coverage of services may continue for up to one year from the date of the health care professional's termination.

» **Psychiatric treatment:** Coverage of services may continue for up to one year from the date of the doctor or health care professional's termination.

These guidelines do not apply if the health care professional is terminated immediately under any of these circumstances:

- In the opinion of Horizon BCBSNJ's medical director, the health care professional is an imminent danger to a patient or the public health, safety and welfare.
- There has been a determination of fraud or a breach of contract by the health care professional.
- The health care professional is the subject of disciplinary action by the State Board of Medical Examiners.

Please call Member Services if you have questions about your continuation-of-care benefits. As always, your benefits are subject to policy limits and normal Horizon BCBSNJ policies and procedures, including prior authorization and utilization management requirements.

Medical technology

We regularly review new medical technology to decide if it is eligible for coverage.

Our review incorporates input from the professional and medical community (including medical practitioners in New Jersey), as well as the research results published in the medical literature. We also review our current policies related to existing technology and amend them as appropriate.

Physician compensation

In general, Horizon BCBSNJ pays participating doctors and other health care professionals in two ways:

» **Fee for Service:** Payment for services each time a member is seen or treated

» **Capitation:** Payment of a monthly per-patient fee, whether or not a member receives services in any given month

These payment methods may include financial incentive agreements. Doctors and other health care professionals may be paid more (rewards) or less (withholds) based on many factors, including member satisfaction, quality of care, control of costs and use of services. (Horizon BCBSNJ does not have withholds as a method of payment.)

You have the right to ask your doctor and other health care professionals about how they are compensated for their services by Horizon BCBSNJ so you will know if there could be any financial incentives or disincentives tied to their medical decisions.

Note: The laws of the State of New Jersey at N.J.S.A. 45:9-22.4 et seq., require that a doctor, chiropractor or podiatrist, who is permitted to make referrals to other health care professionals or facilities in which he or she has a significant financial interest, inform his or her patients of that financial interest when making such a referral.

For more information about compensation, ask your doctor or other health care professional. If you believe that you are not receiving the information to which you are entitled, you may call the New Jersey Division of Consumer Affairs at **1-800-242-5846** or **1-973-504-6200**.

Utilization management

Horizon BCBSNJ's Utilization Management (UM) Program monitors your health care – the care you receive and the care your doctor proposes for you – to assess its medical necessity and appropriateness. Utilization management also lets us help doctors to manage the care they provide in medically appropriate and cost-effective ways. Through UM, we identify best practices that produce high-quality care and health outcomes, and share that knowledge with members, in-network doctors, health care professionals and employers through continuing education.

In particular, we watch for:

» **Underutilization:** Not getting annual checkups or preventive vaccinations as recommended

» **Overutilization:** Getting medical care, medications, laboratory testing or surgical procedures when they are not medically necessary

OUR UTILIZATION MANAGEMENT PRINCIPLES

» We make UM decisions based only on the necessity and appropriateness of care and services within the provisions of the member's benefit package.

» We don't compensate anyone responsible for UM decisions in a way that rewards him or her for denying coverage for medically necessary and appropriate covered services.

» We don't offer incentives to anyone responsible for UM determinations to encourage denials of coverage or services, and we don't provide financial incentives to doctors to withhold covered health care services that are medically necessary and appropriate.

» We emphasize the delivery of medically necessary, appropriate and cost-effective health care services to members, and we encourage the reporting, investigation and elimination of underutilization.

ABORTION COVERAGE

This plan covers certain abortion services. Please call Member Services for more details.

Notice of information privacy practices

Horizon Blue Cross Blue Shield of New Jersey and its affiliated companies[1] want you to know that we are legally obligated to keep information about you secure and confidential. Unlike many other financial and health institutions, we do not sell information about you and we do not share your information except to conduct our business.

As required by law, we publish this Notice to explain the information that we collect and how we maintain, use and disclose it in administering your benefits. We will abide by the statements made in this Notice. Except as permitted by law and as explained in this Notice, we do not disclose any information about our past, present or future customers to anyone. Uses and disclosures not described in this Notice will be made only with your written authorization. When we use the term "Customer Information," we are referring to financial or health information that is "nonpublic," including any information from which a judgment could possibly be made about you. When we use the term "Protected Health Information" or "PHI," we are referring to individually identifiable oral, written and electronic information concerning the provision of, or payment for, health care to you. We refer to Customer Information and PHI collectively as "Private Information."

MEMBERS OF SELF-FUNDED PLANS

If you are a participant or beneficiary of a self-funded group health plan, we may use and disclose your Private Information as described in this Notice. However, our use or disclosure is dictated by an arrangement with your employer (or other sponsor of your benefits plan) or that plan itself. That plan may use and disclose your Private Information differently than is described here. With respect to your individual rights, you should ask your plan administrator how to exercise those rights, along with any other questions you may have regarding your plan's privacy policies and practices. This Notice also applies to Horizon BCBSNJ's employee health benefit plan.

1 The Horizon Blue Cross Blue Shield of New Jersey affiliated companies, all of which are independent licensees of the Blue Cross and Blue Shield Association, are:

Horizon Healthcare Services, Inc. d/b/a/ Horizon Blue Cross Blue Shield of New Jersey.

Horizon Healthcare of New Jersey, Inc., including its Horizon NJ Health (Medicaid/NJ FamilyCare) line of business.

Horizon Insurance Company

Horizon Healthcare Dental, Inc.

Horizon Casualty Services, Inc. (This affiliate is not a covered entity subject to the federal privacy rules.)

WHAT INFORMATION DO WE COLLECT?

In providing your health coverage, we collect Private Information from the following sources:

- Information we receive from you or your policyholder on applications, other forms or websites we sponsor
- Information we obtain from your transactions with us, our affiliates or others, such as health care providers
- Information we receive from consumer-reporting agencies or others, such as Medicare, state regulators and law enforcement agencies

HOW DO WE PROTECT PRIVATE INFORMATION?

Our employees are trained on the need to maintain your Private Information in the strictest confidence. They agree to be bound by that promise of confidentiality and are subject to disciplinary action if they violate that promise. We also maintain appropriate administrative, technical and physical safeguards to reasonably protect your Private Information.

In addition, in those situations where we rely on a third party to perform business, professional or insurance services or functions for us, that third party must agree to safeguard your Private Information. That business associate must also agree to use it only as required to perform its functions for us and as otherwise permitted by our contract and the law. Finally, if we or our business associate causes a "breach" of privacy as that term is defined under federal law, we will notify you without unreasonable delay of the occurrence. In these ways, we carry out our confidentiality commitments to you.

WHEN MUST WE SEEK YOUR AUTHORIZATION BEFORE DISCLOSING PRIVATE INFORMATION?

There may be circumstances where we will seek your authorization before making a disclosure of your Private Information. This is to ensure that we have your permission to make that disclosure. For example, you may have asked someone who is not your personal representative (or the policyholder) to contact us on your behalf to obtain information about your claims. Before we disclose your Private Information to that person, we would seek your authorization to do so, unless otherwise permitted or described in this Notice. Your written authorization is required for (1) uses and disclosures of Private Information for marketing activities, when such authorization is required by law; (2) uses and disclosures of psychotherapy notes; and (3) uses and disclosures that constitute a sale of your Private Information.

If you give us your authorization, you are permitted to revoke that authorization at any time in writing. We will honor your revocation once it is processed, except to the extent that we have taken action in reliance upon your original authorization, or the authorization was obtained as a condition of obtaining coverage.

USES AND DISCLOSURES OF PRIVATE INFORMATION THAT DO NOT REQUIRE AUTHORIZATION

Most of our routine use and disclosure of your Private Information occurs in administering your coverage. In those instances, we are not required to seek your authorization. For instance, we are generally permitted to make disclosures of your Private Information without authorization for purposes of treatment, payment and health care operations. In this Notice, we provide examples of those routine purposes, although not every use or disclosure that falls into those categories is listed.

Please note that we will limit the disclosure of certain information in accordance with laws governing the special nature of the information (e.g., HIV/AIDS, substance use disorder, genetic information). We are prohibited from using and disclosing your genetic information for underwriting purposes. Also, where a state permits minors of a certain age or status to seek treatment without parental consent, information that would normally be provided to our customers may be limited, if requested, and we are informed that treatment was rendered that way. That is because we must protect the privacy of that minor's information in accordance with those state laws.

Payment Activities

We routinely use and disclose Private Information in connection with your health care coverage, to determine your eligibility for coverage and benefits, and to see that the treatment and services you receive are properly billed and paid. To do this, we may share Private Information with health care providers, their billing agents, insurance companies and others. Our payment activities can also include the use of Private Information for: risk adjustment, billing, claims management, collection activities, utilization review, medical necessity determinations, drug rebate contract reporting of drug utilization, underwriting and other rate-setting activities.

For example, a claim for medical services rendered to you may be submitted electronically from a billing service on behalf of your provider. Our claims processors will then use your Private Information to process your claim. If we need additional information to process it, we may contact your provider to obtain that information. When we do that, we disclose Private Information to your provider in order to identify and discuss your claim with him or her. Your provider then discloses the needed, additional Private Information that will enable us to properly process your claim. In this example, each of these entities involved – your provider, his or her billing service and Horizon BCBSNJ and/or its affiliated companies – is covered by and must protect and safeguard your Private Information either because they are "covered entities" or "business associates" of covered entities under the federal privacy regulations.

Health Care Operations Activities

We routinely use and disclose Private Information to conduct our health care business, including all the activities that are defined by federal regulation as "health care operations." They include, but are not limited to: case management and care coordination, utilization review, quality assessment and improvement, network provider credentialing, population-based research to improve health or reduce health care costs, and contacting providers and members with information about treatment alternatives.

For example, we may use and disclose Private Information to remind you about the availability or value of preventive care or of a disease management program. Other health care operations activities include compliance and auditing activities, evaluating provider performance, underwriting, formulary development, information systems management, fraud and abuse detection (by ourselves or for other plans or providers), facilitation of a sale, transfer, merger or consolidation of all or part of Horizon BCBSNJ and/or its affiliated companies with another entity (including due diligence related to the transaction), customer service and general business management, among others.

Health-Related Activities

We may use or disclose your Private Information for a number of treatment-related activities. We are permitted to tell you about possible treatment options or alternatives, inform you of health-related benefits or services, inform you of a relevant disease management program that may be of interest to you, and seek your voluntary participation in such programs to help improve your health and assist in the coordination of your overall health care. For example, our diabetes disease management business associate may, after reviewing PHI that we had provided, determine that you might suffer from diabetes. You may then receive a notice that we have enrolled you in our disease management program. If you do not want further contact about, or to participate in, the program, you only need to notify us. Our business associate would then be instructed to not use or disclose your information further, which it must follow due to its contract with us.

Treatment, Payment and Health Care Operations of Other Covered Entities

We may use and disclose your PHI for another covered entity's treatment, payment and health care operations purposes. For example, we may disclose your PHI when disclosure would facilitate payment for services under another health plan. In addition, we are permitted to disclose PHI to other covered entities so they can conduct certain aspects of their health care operations. We may also disclose it for purposes of their fraud and abuse detection or compliance. But we will only disclose PHI to another covered entity for these purposes if that covered entity has or had a relationship with you.

Disclosures to Family Members

Unless you notify us in writing otherwise, we may disclose your Private Information to certain other family members who are on your coverage. In the context of spouse-to-spouse (or between civil union partners) and parent-to-child relationships, including both minor and adult children, we will deem the spouse/civil union partner or parent on their coverage to be the personal representative of the other spouse/civil union partner and/or the child, as applicable. We will do this unless you notify us in writing that you do not wish that individual to serve as your personal representative. Contact Member Services as described in this Notice to designate or terminate a personal representative involved in your care or coverage.

Under certain exceptional circumstances, such as a medical emergency, we may disclose your Private Information to a person who is involved in your care or payment for that care. We can only disclose your Private Information that is relevant to that person's involvement with your care or payment for that care.

Additional Reasons for Disclosure

We may also use or disclose Private Information to:

- The certificate holder or policyholder of your coverage, if it is information regarding the status of an insurance transaction, as permitted by law;
- Military authorities, if you are or were a member of the armed forces;
- Further public safety or, when requested by federal officials, for national security or intelligence activities or for the protection of public officials;
- Appropriate bodies for public health activities, including the reporting of child abuse or neglect, adverse events, product defects, or for Food and Drug Administration reporting;
- A health oversight agency for activities such as audits, investigations, licensure, disciplinary actions, or civil, administrative or criminal proceedings. These disclosures are necessary for the government to oversee the health care system and government benefits programs, as well as for compliance with standards and civil rights laws;
- Carry out appropriate research, but only as expressly permitted and limited by the federal privacy rules;
- Communicate with legislators and regulators about legislative and regulatory developments and proposals that may impact access to affordable, quality health care;
- Contact you for fundraising purposes. You have the right to opt out of receiving fundraising communications;
- Appropriate bodies in response to a subpoena or court order, or in response to litigation that directly involves us or your group health plan;
- A correctional institution or law enforcement agency, if you are an inmate or in the custody of law enforcement;

- Plan sponsor employees that are designated by the plan administrator as assisting in plan administration. The federal privacy rules require your plan administrator to obtain certain representations from the plan sponsor about how your information will be protected. This is to ensure that the plan sponsor complies with certain privacy requirements and agrees not to use that information for employment-related and other decisions;
- Conduct permissible marketing-type activities, either ourselves or through other companies on our behalf, such as for health-related products or services, or to other financial and health institutions with which we have joint marketing agreements;
- Perform other functions and activities, as permitted by the federal privacy rules.

You should understand that, except as permitted or described in this document, we will not disclose your Private Information without a written authorization from you. And except for disclosures of PHI made directly to you or your personal representative, for your treatment, or pursuant to your authorization, the federal rules require us to use and disclose only the minimum PHI necessary to accomplish our purpose. For example, if we need to disclose your PHI to our utilization review case manager to help determine the medical necessity of a particular claim, we would likely not disclose your entire claim history and medical record. That is because your entire record is probably not necessary to make the determination for that one claim.

LEGAL RIGHTS RELATED TO PI

The federal privacy rules entitle you to:

- Inspect and obtain a copy of your PHI that we maintain about you that is included in what is called a "designated record set". This includes your right to request access to PHI in an electronic format if we hold it that way. But we are not required to maintain it, except for certain documentation related to privacy rules compliance or as may otherwise be required by law.

  This does not include information that relates to, and is collected in connection with or in anticipation of, a claim or civil or criminal proceeding involving you. It also does not include information which we are prohibited by law from releasing. You must reasonably describe the information you seek in your written request, and the information must be reasonably locatable and retrievable by us. We may charge you a fee to cover the cost of providing this Private Information. Information is usually provided within 30 days of your request.

  You may have a state law right to request, in writing, to inspect and obtain a copy of Private Information about you.

- The federal privacy rules create a right to request amendment of your PHI included in the designated record set. We may deny your request under those rules if we determine that our records are accurate and complete or were not created by us, the information is not contained in our designated record set, or access is otherwise restricted by law.

State law may entitle you to request that we amend or delete Private Information about you in our records if you believe the information is incorrect or incomplete. We may deny this request. However, if we do so, we must advise you of the reasons for the denial and advise you of your right to file a statement of rebuttal.

- The federal privacy rules entitle you to request restrictions on our use and disclosure of PHI for treatment, payment or health care operations (described in this Notice). We will consider each request, but are not required to agree to any restrictions, except a reasonable request for confidential communications.
- The federal privacy rules entitle you to request to receive confidential communications of PHI if disclosing this information by the usual means could endanger you. We will accommodate all reasonable requests, subject to the restrictions and capabilities of our information processing systems. A verbal request may be considered, but must be followed up in writing.
- The federal privacy rules entitle you to request to receive an accounting of certain disclosures of your PHI made by us, such as disclosures to health oversight agencies. These do not include disclosures made for purposes of treatment, payment or health care operations, disclosures to you or authorized by you, and for certain other reasons. A similar right may exist under state law.
- You have the right to request and obtain a paper copy of this Notice, even if you previously agreed to receive it electronically.

If you wish to exercise any of the legal rights described in this Notice, you must do so in writing. To obtain further information about these rights, or if you would like to make such a request, please contact either:

Horizon BCBSNJ Member Services
PO Box 820
Newark, NJ 07101-0820

or call:
1-800-414-SHBP (7427)

KEEPING UP TO DATE WITH OUR PRIVACY PRACTICES

Horizon BCBSNJ and its affiliated companies reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all information that we maintain. Our policies may change as we periodically review and revise them. We will provide you with a new Notice if the changes are significant. A copy of our Notice can be found at **HorizonBlue.com/privacy-policy**. We will also provide you with a Notice of Information Privacy Practices (or a summary of the Notice) annually, as long as you maintain an ongoing insured customer relationship with us.

It may be necessary to use or disclose your Private Information as described in this Notice even after coverage has terminated. In addition, it may be infeasible to destroy your private information. Thus, we do not necessarily destroy it upon the termination of your coverage. However, any information we keep must be kept secure and private, and used only for permissible purposes.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with Horizon BCBSNJ and its affiliate companies by calling Member Services at **1-800-414-SHBP (7427)**, or by writing to:

Horizon BCBSNJ Privacy Office
Three Penn Plaza East, PP-16F
Newark, NJ 07105-2200

You may also complain to the U.S. Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.

All complaints must be submitted in writing. A verbal complaint will be processed, but we request that it be documented in writing. If you have any questions regarding the content of this Notice, you may call the Privacy Office at **1-973-466-5781**.

Women's Health and Cancer Rights Act of 1998

Under federal legislation, notification of this benefit is required to all members.

In 1998, the federal government enacted a law that mandates certain health coverage for breast reconstructive surgery in any health program that provides medical and surgical benefits for mastectomies. This law is known as The Women's Health and Cancer Rights Act.

If a covered person is receiving benefits in connection with a mastectomy and elects to have breast reconstruction along with that mastectomy, the policy must provide in a manner determined in consultation with the attending physician and the patient, coverage for the following:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to deductibles and coinsurance to the same extent as for any other illness under your coverage.

All other features and benefits of this program remain the same and are not impacted by this notification.

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